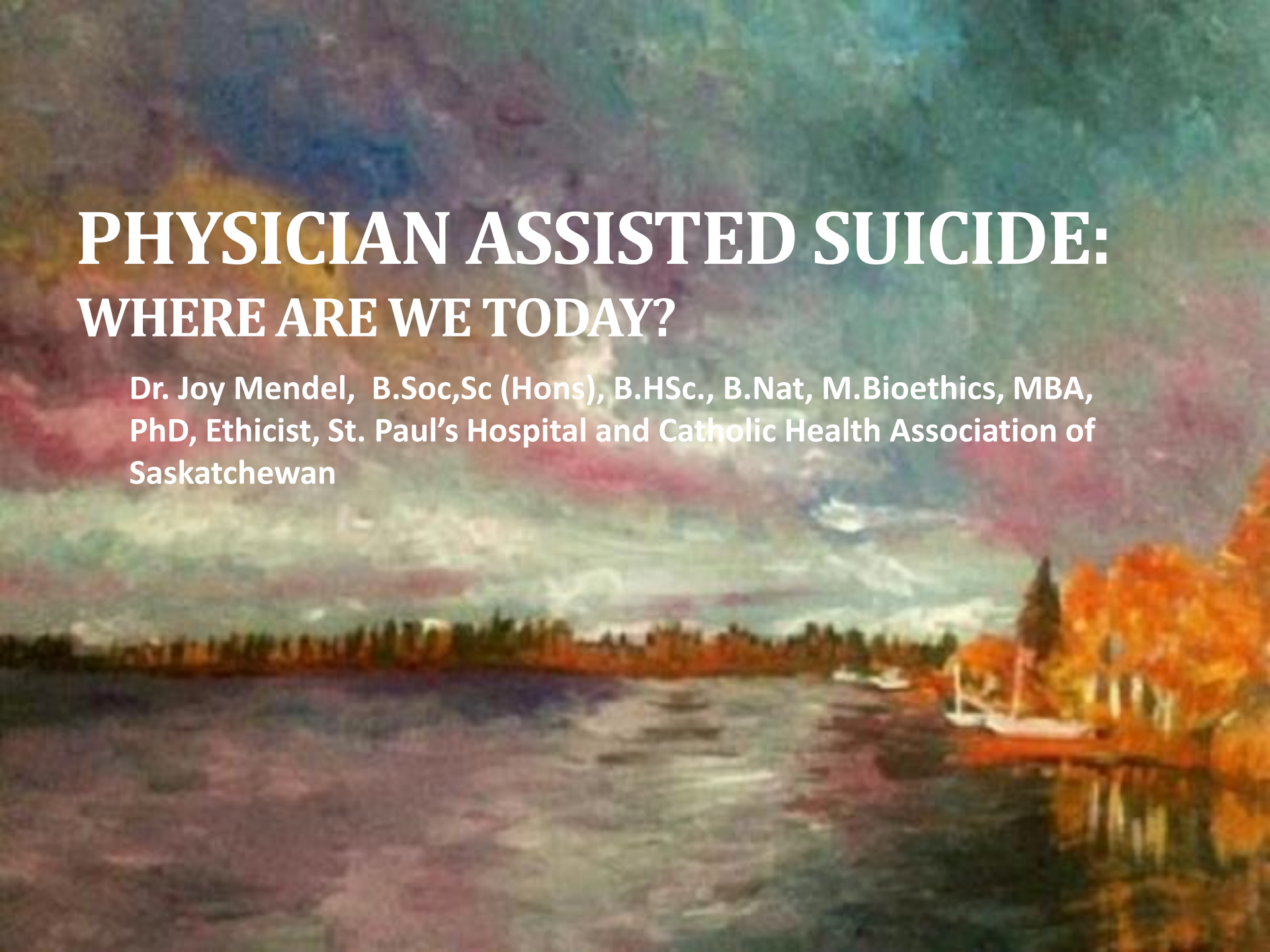


PHYSICIAN ASSISTED SUICIDE:
WHERE ARE WE TODAY?

Dr. Joy Mendel, B.Soc,Sc (Hons), B.HSc., B.Nat, M.Bioethics, MBA, PhD, Ethicist, St. Paul's Hospital and Catholic Health Association of Saskatchewan

Contents

1) Understanding the Carter Decision
2) Current events
3) Implications for Canadian Society
4) Implications for organizations and next steps

History and current events

History

1983 Recommendations from Law Reform Commission:
Assisted suicide should not be legalized or decriminalized.

1991 The first assisted suicide Bills are introduced into Canadian parliament. They do not pass.

1993 Sue Rodriguez from BC a patient with ALS, files a suite in the BC Supreme Court challenging laws against assisted suicide.

Rodriguez 1993

Also argued using Canadian Charter or Rights and Freedoms:

Section 7

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Section 12

Everyone has the right not to be subject to cruel and unusual punishment.

Rodriguez 1993

- Majority in a 5-4 decision challenge dismissed:

- Section 7 of the Charter of Rights and Freedoms protected Sanctity of Life.

- “society has a reluctance to support assistance to a person to bring about death in the case of a terminal illness”.

History

2012 Carter v. BC "The Taylor Case"

ALS patient Gloria Taylor, The British Columbia Civil Liberties Association and others.

Taylor also argues that S. 241(b) of the Criminal Code violates her right to physician assisted suicide.

Government given 1 year to legislate

Taylor given an exemption

2013 Carter et. al. v. Canada (Attorney General) - Court of Appeal

Court of Appeal overturns Justice Smith's decision and upholds the ruling in Rodriguez. Claim J. Smith had erred in applying the Rodriguez precedent.

2014 (October 15th hearing)

Carter v. Attorney General - Appeal to Supreme Court of Canada.

2015 (February 6th)

Supreme Court unanimously strikes down Section 241(b) of the Criminal Code, claiming it infringes on all three of the life, liberty and security of person provisions in Section 7 of the Charter of Rights and Freedoms.

Parliament given 12 months to draft new legislation.

To whom does the SCC decision apply?

"a competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition, including an illness, disease or disability, that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."

How the government can respond

- Legislate very narrowly – base on SCC decision
- Legislate more broadly
- Invoke the ‘notwithstanding clause’
- Do nothing
  - In this case on February 7th 2016 Section 241(b) of the Criminal Code will no longer be in effect.

Quebec situation

Quebec has its own legal system.

Long history of assisted suicide Bills prior to Bill 52

Bill 52 – ‘An Act Respecting End of Life Care’

Passed in June 2014 (in effect December 2014)

Current events

3 member Federal panel on Assisted Suicide

Ontario panel on Assisted Suicide

Physician's Colleges

Canadian Medical Association

Election

All parties seem to have steered away from assisted suicide as an election issue.

Around the world

Netherlands

United States:

- Legislation: Oregon, Washington State, Vermont, now California
- Case law: Montana (under challenge), New Mexico

Belgium

Switzerland

Switzerland - 1940
Oregon (U.S.) - 1994
Colombia - 1997
Netherlands - 2002
Belgium - 2002
Washington (U.S.) - 2008
Luxembourg - 2009
Montana (U.S.) - 2009 (court ruling only)
Vermont (U.S.) - 2014
New Mexico (U.S.) - 2015 court ruling under appeal)
Quebec (Can.) - 2015
California (U.S.) - 2015
Canada - 2016 (details pending)

Maryland may be next.

Belgium

Euthanasia legalized in 2002.

Doctors can help patients to end their lives when they freely express a wish to die because they are suffering intractable and unbearable pain.

Patients can also receive euthanasia if they have clearly stated it before entering a coma or similar vegetative state.

A method of euthanasia is not described in law

1,807 people euthanized in 2013 (1,432 in 2012, 708 in 2008 and 235 in 2003). Just over half of cases last year were aged 70 or over.

- 2014 Assisted Dying laws passed for children.

CHAC Ethicist Group

Key Messages:

Witness to sanctity of all human life

Advocate for access to palliative care

Refuse to provide and participate in Physician Assisted Death.

Uphold the rights of patients and families acting on an informed decision about end of life care

(including the right to decline or cease life sustaining interventions and receive pain relief)

CCCB

Care for people – do not kill them

Advocate for access to palliative care

"In the face of the terrible suffering that can be caused by illnesses or depression, **a truly human response should be to care, not to kill.** Likewise, the response to the anguish and fear people can experience at the end of their lives is to be present to them, offering palliative care, not intentionally to cause their death. The need for palliative care should be one of the most pressing preoccupations of our country and its institutions. This is where the energies and resources of our elected leaders should be directed. **This is why we advocate making high-quality palliative care, long-term care, and home care easily accessible to all Canadians.**" (CCCB Statement on Assisted Suicide 18th September 2015)

- Call for notwithstanding clause to be invoked (5 years)
- Protect conscience rights of health care workers

"Furthermore, we **must at all cost uphold and protect the conscience rights of the men and women who work as caregivers**. Requiring a physician to kill a patient is always unacceptable. It is an affront to the conscience and vocation of the health-care provider to require him or her to collaborate in the intentional putting to death of a patient, even by referring the person to a colleague. The respect we owe our physicians in this regard must be extended to all who are engaged in health care and work in our society's institutions." (CCCB)


Implications
for society

Implications for society

- Protection of vulnerable people may be difficult
- Normalization of assisted suicide as a way to die
- Changes in role of medical profession

Implications for society

Sanctity of human life being replaced?

- Idea of usefulness and/or quality of the person's life
- 'my choice or rights' – personal preference
- Shift to Moral relativism

Shifting sands?

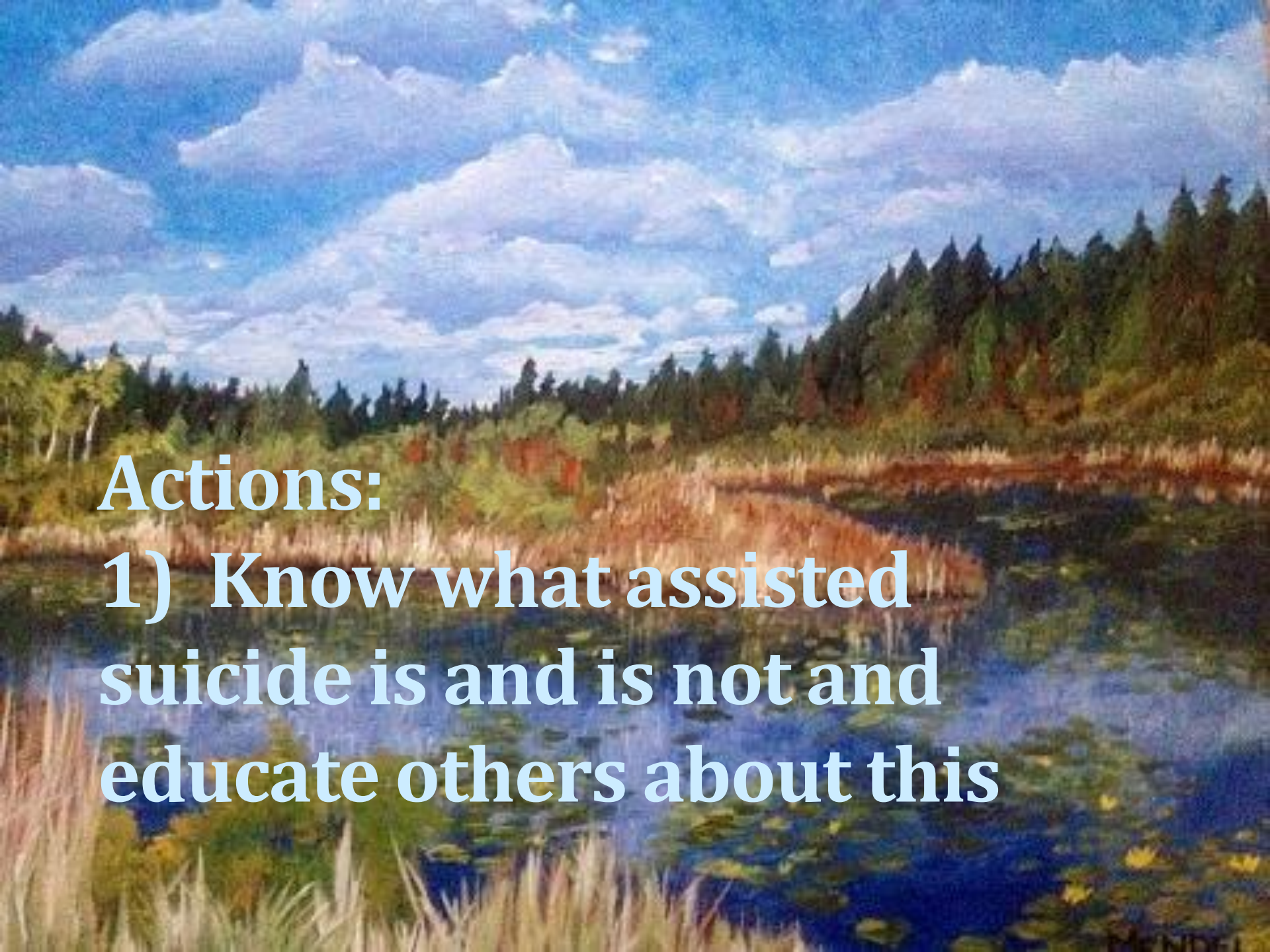
Belgium:

Netherlands:

Implications and next steps for organizations

Questions remain about health systems

- Health systems and organizations
- Doctors and other health care workers
- How will the issue regarding referral play out?
- Will conscience be protected?
- Other issues not addressed in the SCC decision


Actions:
1) Know what assisted suicide is and is not and educate others about this

Issues

- Know the differences
- Address confusion
- Terms in palliative care:
  - Double effect and pain relief
  - Palliative sedation
  - Withholding and withdrawing intervention when little or no benefit or too burdensome.

Issue with use of terms

" Palliative sedation therapy is the use of medications to sedate, either lightly or deeply, a person who is experiencing intractable symptoms such as shortness of breath, confusion or pain when all regular methods have failed or are not possible. Research shows that palliative sedation therapy does not invariably shorten life." p. 27 Health Ethics Guide

Bill 52 uses term of **“terminal palliative sedation”**

Continuous administration of medication to relieve suffering by rendering a person unconscious until he or she dies. Intention of this activity is to bring about the person’s death. It is therefore assisting a suicide and is illicit.

Dignity

Respect for Human Dignity: human dignity comes from the fact of creation. *Imago Dei* "We are made in the image of God"

i.e. life is to be respected from conception to natural death.

- It is inherently wrong kill another person or to help them to kill themselves

- The answer to suffering is NOT to end life.

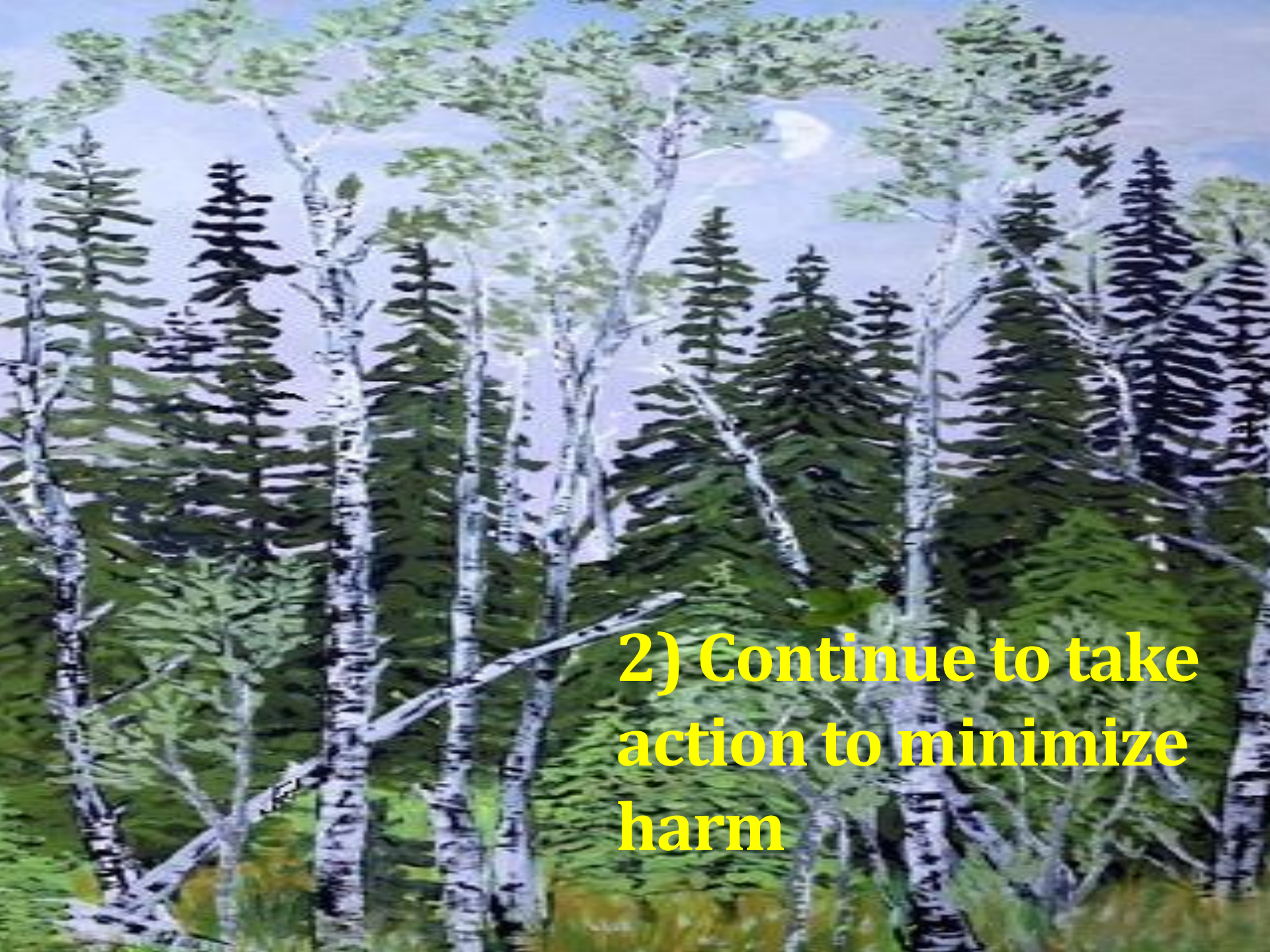
"The Assisted Suicide" debate focuses attention on the importance to humanity of putting into practice the belief that all human life has dignity and deserves respect and protection."

(Margaret Somerville)

Summary of actions

Educate patients, residents, families – and public

- Education sessions for public:
  - Clarify terminology
  - What palliative care is and is not. Pain and
  - Support palliative care


2) Continue to take action to minimize harm

Lobby

- Pastoral letter – Catholic Bishops of Saskatchewan.
  - Lobby local member and government.
  - Lobby organizations seeking to direct the course of assisted suicide.

Current Consultations

College of Physicians and Surgeons of Saskatchewan

https://www.cps.sk.ca/

3 member Federal panel on Assisted Suicide

Until Oct. 19 to submit their personal views to the panel

Until Nov. 1 to complete the panel's "issue book," an online questionnaire that asks people to submit their opinions on a wide range of issues relating to doctor-assisted suicide.

http://www.ep-ce.ca/issue-book/

Send a message to the panel

http://www.ep-ce.ca/contact-us/

Ontario panel on Assisted Suicide

http://www.ontario.ca/page/doctor-assisted-dying-and-end-life-decisions-consultation


3) Protect and support our palliative care services

Protect palliative care

1) Maintenance of public confidence in palliative care services:

- Palliative care is the alternative to an assisted suicide.

2) Maintain morale of those involved in providing palliative care:

3) Catholic organizations cannot govern assisted suicide

4) Separation of assisted suicide from palliative care services provides clear boundaries.

Protect and Promote Palliative Care

- The World Health Organization states:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- *provides relief from pain and other distressing symptoms;*
- *affirms life and regards dying as a normal process;*
- *intends neither to hasten or postpone death;*
- *integrates the psychological and spiritual aspects of patient care;*
- *offers a support system to help patients live as actively as possible until death;*
- *offers a support system to help the family cope during the patients illness and in their own bereavement;*
- *uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;*
- *will enhance quality of life, and may also positively influence the course of illness;*
- *is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.*

Palliative Care

The Health Ethics Guide of the Catholic Health Alliance of Canada (2012) defines palliative care in the following way:

- *Palliative care, as a philosophy of care, is the combination of active and compassionate therapies intended to comfort individuals and their support communities who are facing the reality of impending death. It strives to meet physical, social, and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices. Palliative care is not limited to the end of life when a person has only days, weeks or months to live. Persons with progressive incurable illnesses may benefit from palliation of symptoms and other problems much earlier in their illness trajectory, even when they are receiving treatments such as chemotherapy to control their illness.*

In 87 of the Health Ethics Guide, it is stated

- *"Treatment decisions for the person receiving care are never to include actions or omissions that intentionally cause death (euthanasia)"*

Note that the Canadian Hospice and Palliative Care Association, at least on its website, does not include a statement that hospice palliative care does not hasten death or a statement that actions which intentionally cause death are opposed to palliative care. Rather, it speaks of helping people to "prepare for and manage self-determined life closure and the dying process"

Action needed – to ensure palliative care continues to be defined in our organizations to include not intentionally hastening death.


4) Protect
freedom of
conscience

“Disregarding physicians’ right to freedom of conscience….. promotes an image of the human person as someone who can be detached from his or her moral reasoning,” Bishop Don Bolen

- Moral distress for doctors
- Could trigger a professional crisis if made to refer.

Conscientious objection and doctors

- 63% of doctors would not assist a suicide
- Immediate past president supports conscientious objection including objection to referral for assisted death.

Ontario College Physicians and Surgeons: referral is essential

Saskatchewan draft (College of physicians and surgeons – provision of information and not blocking access)… may change.

Protect Freedom of conscience and non-abandonment

No one may be required to participate in an activity that in conscience the person considers to be immoral. While continuing to fulfill its mission, the organization is to provide for and to facilitate the exercise of conscientious objection without threat or reprisals. However, the exercise of conscientious objection must not put the person receiving care at risk of harm or abandonment. This may require informing the person receiving care of other options for care. (Health Ethics Guide 165)

Raises questions

- How far can a doctor or health care worker go regarding non-abandonment of the patient?

- Oregon: staff have no involvement in assisted suicide.
- Washington DC

How far can a doctor or health care worker go regarding non-abandonment of the patient?

Physicians have a duty of ‘non-abandonment’ - but does it require referral in the case of an issue, such as assisted suicide, to which a doctor has a conscientious objection?

Referring to a provider who then assists a suicide is formal cooperation (illicit)

Referral to an intermediary (to discuss, for information) may be acceptable.

Referral, accepting that there may be no actual intention on the patient’s part to have an assisted suicide may be acceptable (Coughlin 2015)

Provision of Information vs. counselling towards/leading

- there is a difference between informing and ‘leading or counselling a person towards’ an immoral action.

5) Identify potential issues for your organization

Protect organization's rights to own mission and values

- Collaborative partnerships are important to help us continue our mission. However:
  - Make it clear that the organization retains a right to uphold its mission and moral values e.g. affiliate agreements with health regions.
  - Make it clear that in shared policy situations, the policy should be developed by all impacted and that certain issues are 'non-negotiable'

Cooperation

- Formal cooperation – always illicit:
  - Involves intentionally assisting and intending an illicit action. e.g.
    - Assisting a suicide.
    - Prescribing medications that a person will then use to commit suicide.
    - Being in a management or governance (board) role over an assisted suicide.
    - Some would argue, referring for an assisted suicide. is formal cooperation (illicit) while referring for information, would be a mediate form of cooperation (and therefore licit)

Examples of Issues:

- Staff who work at other sites.
- Pharmacy staff
- Pharmacy stock
- Governance roles an responsibilities
- How do doctors work in the organization
- Monitoring and responding to moral distress

Partnerships

As affiliates we uphold our mission, values and ethical positions.

- However, ensuring they are not compromised by the Health Region milieu and policies may be a challenge.

- Need to think about:
  - Are our staff involved in services where they may be expected to assist a suicide?

Actions: Partnerships

- Influence policy
- Guidelines/procedures for staff on communication –
  - We want to be compassionate while delivering our message that we don't assist suicide.


6)What can we do if our procedure not followed?

The issue

What happens if a health care worker witnesses or hears of an assisted death at one of our organizations?

-

Section 27.4(g) HIPA

(g) where the disclosure is being made to a standards or quality of care committee established by one or more trustees to study or evaluate health services practice in a health services facility, health region or other health service area that is the responsibility of the trustee, if the committee:

(i) uses the information only for the purpose for which it was disclosed;

(ii) does not make a further disclosure of the information; and

(iii) takes reasonable steps to preserve the confidentiality of the information;

Privacy Commission

"Studying or evaluating health services", is not defined in HIPA.

- Thinking of amending HIPA to define a meaning.
- Other jurisdictions e.g. examining existing services to improve outcomes, risk management, error management, improve services, improve programs or services.
- The disclosure has to tie back to the services being studied or evaluated.

Governance/Privacy Issues

Only for study or evaluation

This means that the information gathered stops with:

- studying quality or care (i.e. does not mean for the purposes of punishing and individual)

- is not reported outside the committee

Members of such committees with ‘different hats’

No situations in which the Commission has had to determine whether information provided to a quality committee was appropriate.

SHR Legal Counsel

- Disclosure of an assisted suicide to a quality committee does not meet the definition under the Act.

- Says look at what you are doing – i.e. seeking health information for the purpose of punishing someone e.g. a doctor for undertaking a legal activity which breaches policy.

The trustee – if they the issue came up would be in a better position something about it.

In Summary

There may be no legal way for management or board to know if a breach has occurred.

7) Communicate

Communications - Now

Communication with staff that assisted suicide will not be practiced at (name of organization).

Why important? - many staff are uncertain and feel moral distress about the SCC decision.

Information for patients, residents and families

- Upon entry to LTC (in hospitals… when? When hearing of a terminal diagnosis?, general information brochures?)… position on assisted suicide.
  - Compassionate approach
  - Assisted suicide will not be provided at…. because…
  - The alternative is palliative care…
  - Palliative care involves….

For future

1) Communication with physicians that assisted suicide will not occur at the hospital or LTC home.

2) Explicit instructions provided to staff regarding requests for assisted suicide.

8) Have compassion

A person who is contemplating suicide for any reason needs our care and support.

People do feel like dying due to factors such as existential grief,

Symptoms they would rather not live with, feel ‘tired of life’ etc.

‘Getting on a high horse’ about right and wrong with this person is not the way to go either.

Love and care rather than judgment.

Make sure there is access to good palliative care and the person knows about that option.

There may, however, be future decisions about how far we can continue to ‘walk with’ a person intent on accessing assisted suicide.

"True compassion leads to sharing another's pain; it does not kill the person whose suffering we cannot bear."

Pope John Paul II , *Evangelium Vitae*, 1995

Question remains unsettled at this stage – how far can we travel with a person who is intent on ending his/her life through assisted suicide?


9) Stay updated

Over coming weeks and months we may see:

1) Information on the course to be taken on assisted suicide from the incoming government.

2) Report from the 3 member panel on Physician Assisted Death

3) Further information from the Catholic Health Alliance of Canada.

4) Possible – statements from Bishops.

Action Summary

1) Know the issues – educate others
2) Act to minimize harm of assisted suicide
3) Act to protect palliative care.
4) Act to protect the right to conscientious objection
5) Identify potential issues for your organization.
6) Recognize that some issues are yet to be decided:
   - referral issue (for what, how?)
   - what can be done about non adherence to policy/procedure
7) Remain compassionate
8) Communicate
9) Stay updated


Thank you

Bibliography

Bishops of Saskatchewan: Pastoral letter to the Catholic Faithful on the Legalization of Assisted Suicide and Euthanasia, July 13 2015

Carter v. Canada (Attorney General): Decision Summary
http://www.cmdscanada.org/my_folders/PAD/CarterDecisionSummary.pdf

Carter v BC (Gloria Taylor Case).
http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886.htm

Catholic Health Alliance of Canada, Physician-Assisted Suicide and Euthanasia Briefing, September 2015.

Coughlin M (2015) Referral: Balancing Conscience and non-abandonment: considerations around referral in the context of physician-assisted death, Based on discussions of a meeting of Ethicists organized by the Catholic Health Alliance of Canada, Toronto, June 24-25.

Health Information Protection Act, Saskatchewan, 1999.

Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan 1997

Johnston W, "Rebranding Killing and Suicide: The Ugly Truth About Euthanasia," *Huffington Post*, August 19, 2013, http://www.huffingtonpost.ca/will-johnston/euthanasia-assisted-suicide_b_3779914.html.

Health Ethics Guide, Catholic Health Alliance of Canada 3rd edition, Ottawa, 2012.

Johnston W, “Rebranding Killing and Suicide: The Ugly Truth About Euthanasia,” *Huffington Post*, August 19, 2013, http://www.huffingtonpost.ca/will-johnston/euthanasia-assisted-suicide_b_3779914.html.

National Assembly: Quebec, “Bill no. 52: An Act respecting end of life care” info page, http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi-52-40-1html

Smith M, The Sue Rodriguez case: A review of the supreme court of Canada decision on assisted suicide:
http://publications.gc.ca/Collection-R/LoPBdP/BP/bp349-e.htm#MAJORITY DECISION - MR. JUSTICE SOPINKA

Somerville M, Are Canadian’s Confused, Lecture given 4th November, 2014, Saskatoon.

Statement on Assisted Suicide issued by the Plenary Assembly of the Canadian Conference of Catholic Bishops Friday, September 18 2015 - Last Updated Friday, September 18 2015

World Laws on Assisted Suicide, accessed 14th October 2015, available at:
http://www.finalexit.org/assisted_suicide_world_laws_page2.html